2001 Annual Report

Office of Inspector General

Illinois Department of Public Aid

George H. Ryan
Governor

Robb Miller
Inspector General

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March 1, 2002

To the Honorable George H. Ryan, Governor, and Members of the General Assembly:

I am pleased to present you with the Office of Inspector General's Calendar Year 2001 Annual Report, which presents the activities that help to ensure the integrity of Illinois human service programs.

During the last year, the office reviewed more providers and more recipients in a variety of innovative ways than ever before. Our goals have been to promote awareness of program integrity, enhance our monitoring techniques and increase fraud detection. Every recipient and every provider should understand that vigilance is a reality and scrutiny is always a possibility.

As required by Public Act 88-554, this report provides data on payments to medical providers at various earning levels, audits of medical providers, savings generated by the prescription Refill Too Soon program, sanctions against providers and investigations.

I hope the OIG's 2001 Annual Report is a valuable resource to you and your staffs.

Sincerely,

Robb Miller, CFE
Inspector General

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OIG Background

Introduction

The Office of Inspector General (OIG) has been in existence since 1994, created by the General Assembly as a part of the Illinois Department of Public Aid (DPA). The General Assembly gave the Inspector General (IG) the mandate "to prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct" in programs administered by DPA. The IG reports to the Governor, who appoints the IG to a four-year term that requires confirmation by the Illinois Senate. The OIG operates within the DPA budget, but acts independently of DPA.

Scope

Today, the OIG investigates misconduct in programs administered by DPA and DPA legacy programs in the Department of Human Services (DHS). During the OIG's history, DPA directors and DHS secretaries have acknowledged the OIG's independence, maintained communications and provided the support to realize the shared goals of promoting program integrity and assuring access to medical and financial assistance for those in need.

OIG pursues its mandate by enhancing and developing the tools and techniques to promote prevention, expand surveillance and fight fraud and abuse in Medicaid, KidCare, food stamps, cash assistance, child care and many other social services. The OIG also enforces the policies of DPA, DHS and the State of Illinois.

Staffing

The OIG's integrity posture starts with the staff's proven dedication to finding ways to attack fraud and to work closely with local, state and federal agencies that share the OIG's goals. The OIG has an authorized staffing of 297 employees, who are investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers, information specialists and administrative staff.

Legislation

In August 2001, Governor George H. Ryan signed into law a provision that a Medicaid provider terminated by another state or federal agency can have enrollment terminated or denied in the Illinois Medicaid program. The new law, P.A. 92-327, also applies to health care providers convicted elsewhere of a felony involving Medicaid, Medicare or a private insurance plan. The law took effect January 1, 2002.

TOOLS FOR SUCCESS

Teamwork
The OIG staff understands that it cannot prevent fraud and abuse on its own. Its effectiveness comes from a commitment to team building within the OIG, to working with various partners and to finding collective approaches to program integrity. The team approach has been most effective with the OIG's primary partner, DPA's Division of Medical Programs (DMP), which administers the $7.3 billion medical assistance program -- the single largest entity under the OIG's purview. The medical assistance program includes Medicaid and several state-sponsored programs. A perfect example of the teamwork is the Medicaid Fraud Prevention Executive Workgroup (MFPEW), which has representatives from the OIG, DPA's DMP and Bureau of Information Services. The MFPEW meets monthly to examine common problems and fashion solutions to promoting Medicaid's integrity.

National Recognition
Over the years, DPA and the OIG have received national recognition for developing and deploying a host of best practices. The year 2001 reaffirmed that. The U.S. General Accounting Office, the auditing arm of Congress, gave extensive attention to the OIG in a report entitled "*Strategies to Manage Improper Payments: Learning from Public and Private Sector Organizations,*" issued in October 2001.

Illinois was one of only three states, as well as three federal agencies and three foreign governments, profiled for their best practices by the GAO report. Illinois received mention for DPA's Payment Accuracy Review (PAR) done in 1998 -- the nation's first statistically-valid study undertaken by a state, OIG's data mining efforts, Fraud Prevention Investigations and the OIG's Fraud and Abuse Executive. The GAO report can be read in its entirety on the OIG's website at www.state.il.us/agency/oig.

Networking
OIG employees have been active in the Association of Inspectors General, a national group supporting the work of IG's at local and state levels, and in the federal Centers for Medicare and Medicaid Services' (formerly the Health Care Financing Administration) Medicaid Fraud and Abuse Technical Advisory Group (TAG). The OIG staff also has active roles in the National Welfare Fraud Directors Association, United Council on Welfare Fraud, National Health Care Anti-Fraud Association, National Association for Program Information and Performance Measurement, National Internal Affairs Investigators Association and the American Society for Industrial Security.

Technology
Recent technological enhancements have enabled the OIG's staff to be even more focused in analyzing huge storehouses of information and searching for fraud and abuse in different forms and different areas.

With DPA's Data Warehouse, OIG staff has ready computer access to five years of Medicaid data on recipients, providers and payees. The data includes the paid and rejected claims submitted by providers, provider and payee enrollment information, recipient eligibility information and a wide rage of reference information. The data warehouse gives OIG analysts the tools to help identify fraud and supports OIG audits, investigations and prosecutions. Implementation of the Client Server-Surveillance Utilization Review Subsystem (CS-SURS) will enhance the OIG's ability to monitor DPA's $7.3 billion medical assistance budget. CS-SURS will make data retrieval speedier and more adaptable for checking utilization of medical services, levels of medical care and quality assurance.

The OIG staff deployed new software, Vality, that greatly aided the review of more than 35,000 emergency child support checks issued by DPA's State Disbursement Unit for three months ending in January 2000. Vality helped the staff to do complex matches of names and addresses on different databases. This was the first time any Illinois state agency had used the software package.

The OIG's Bureaus of Internal Affairs (BoIA) and Information Technology (BIT) collaborated to develop computer forensics for monitoring employee abuse of personal computers, e-mail and the Internet. Using the technology, OIG has investigated 22 cases of alleged infractions by DPA employees. Some cases have resulted in employee discharges, resignations, suspensions and reprimands.

Federal Partnership

Through a special partnership with the U.S. Department of Health and Human Services (HHS), DPA and the OIG reviewed whether hospitals were paid according to Illinois Medicaid policy when patients were transferred from one hospital to another. HHS' Offices of Inspector General and Audit Services collaborated with the OIG and DPA's DMP on the partnership project.

Federal/state partnership: Effective use of scarce resources

Using the tools of the data warehouse and analytical software, the OIG's Fraud Science Team analyzed claims and identified instances in which patients were discharged from one hospital and admitted to another on the same day between July 1, 1996, and February 28, 2000. Hospital inpatient stays are generally subject to Diagnostic Review Group (DRG) reimbursements, and hospitals are typically paid less than the full DRG amount when a patient is transferred between hospitals. A transfer that is improperly reported as a discharge results in an overpayment because both hospitals receive full DRG payments instead of the lesser payment for a transfer.

The analysis identified about $1.7 million in possible overpayments for 229 claims paid to 88 hospitals. The OIG sent letters to the hospitals requesting that they document their claim codes as discharges or make restitution to the state. The hospitals either repaid the overcharges or provided additional documentation to indicate the original discharge code was correct. Through this process, the OIG has recovered nearly $1 million. DPA has been implementing the project's

recommendations to provide additional guidance to hospitals on the importance of correctly coding transfers and discharges and to review effective controls in the claims processing system to detect inpatient hospital claims that were improperly coded as discharges. The HHS final report issued in June 2001 concluded "that state and federal oversight groups working together is the most effective and efficient use of scarce federal and state resources." Based on the success and the lessons learned from the original project, a second effort is being launched in 2002 to review more claims for hospital patient transfers.

The full HHS OIG report can be read on the OIG's website, www.state.il.us/agency/oig.

Medicaid Integrity Process Review

The OIG has brought together those office operations that deal with Medicaid integrity to examine existing processes for spotting fraud and abuse and taking disciplinary action against those providers and recipients who abuse the system. Over the course of nearly two years, participants have devised methods to sharpen the focus for identifying and targeting potentially errant providers and recipients and have developed ways to make the overall system operate more effectively. The Medicaid Integrity Process Review has improved communications among the various OIG operations, encouraged innovative thinking and enhanced teamwork and team problem solving. The review has initiated projects to select the worst providers for review, to keep the pipeline flowing with the best cases for review and to improve information sharing within the OIG so the entire process can work more efficiently to discipline the abusive providers, restrict abusive clients and recover public funds.

Child Support Clearinghouse

To address the increasing number of child support inquiries coming to the OIG via the Internet, telephone and regular mail, the IG designated a staff person to get personally involved in each inquiry. Most problem child support cases are complex, cannot be solved in a day with a single telephone call and require follow-up work. Missed payments, intercepted income tax refunds and complicated account balances take time to research and decide what the next steps should be.

The OIG staff person works closely with Division of Child Support Enforcement staff to get answers and find solutions. During the process, the OIG staffer maintains contact with each citizen through a letter or electronic mail. The staff person contacts each person at least once every 30 days until the case has been resolved.

During calendar year 2001, 150 requests were handled by the staff person. By the end of the year, 141 had been investigated and closed. Of the completed referrals, 65% had a legitimate problem requiring attention. Half of the contacts were made by responsible relatives and half by custodial parents. The major complaints involved not receiving child support payments on time and needing assistance to complete modification requests.

Focus on Pharmacy

Prescription Drugs

The cost of prescription drugs in the Illinois Medicaid budget has risen by170% in the last eight years, surpassing $1 billion in State Fiscal Year 2002. The swift rise in this expenditure has attracted more resources to get the spending under control and more efforts to ensure spending integrity. Through the Refill Too Soon modifications, probe audits, a first-ever fraud alert and contracting for pharmacy expertise, the OIG has devoted more time and energy to the prescription and distribution of medications to Medicaid recipients in the community and long-term care facilities.

Illinois' Medicaid Spending on Prescription Drugs

FY1995	**$ 408 million**
1996	**509**
1997	**529**
1998	**583**
1999	**668**
2000	**790**
2001	**975**
2002	**1.10 billion***

*Appropriation

Refill Too Soon (RTS)

During 2001, DPA adopted two RTS measures that will save Medicaid dollars. The first measure involves refilling prescriptions before the supply has been exhausted. The measure calculates the remaining days supply in the previous prescription and applies it to the subsequent refill of that prescription. Recipients still receive all of their appropriate medication, but DPA avoids filling excessive prescriptions for the recipient. This will potentially reduce the maximum number of 30-day prescriptions a patient could receive for a particular drug to 13 from 15 a year. A study conducted by the MFPEW estimated the savings at $1.1 million a month.

The second measure prevents recipients from receiving an illogical or excessive supply of medication; e.g., 30 tablets for a one-day supply. MFPEW (Medicaid Fraud Prevention Executive Group) studied the prescriptions filled for 100 recipients at each of the 10 largest pharmacy providers for a month. The results indicated more than 7,600 claims worth nearly $1 million would not have been approved for payment. The measure reduces the amount of pharmaceutical claims inappropriately paid by DPA, further enhances the RTS program and improves the accuracy of claim information.

Pharmacy Probe Audits

The OIG initiated modified prescription reviews or limited probe audits of about 30 pharmacies in 2001. The review targets randomly-selected prescriptions billed by the pharmacy during a selected six-month period. The review verifies if the drug billed to Medicaid was prescribed by a medical practitioner, the quantity prescribed, the strength and the dosage. Each review takes about a week to complete. Actual overpayments identified are recouped from the pharmacy.

Depending upon the findings, a probe audit could expand to a full review involving the examination of the randomly-selected prescriptions. Although the OIG does not expect to recoup large overpayments per probe audit, the office believes the approach will increase program integrity awareness and serve as a reminder to a larger number of pharmacies that scrutiny is always a possibility.

To improve current review procedures and recommend changes for better identification of pharmacies for review, DPA has contracted with two university-based pharmacy experts as consultants to the agency and the OIG. Their industry perspectives and experience will contribute to an enhanced monitoring of industry practices and policies deserving OIG review.

First Fraud Alert Issued

With the assistance of individual pharmacists, the Illinois Pharmacists Association (IPA) and the Illinois Retail Merchants Association (IRMA), the OIG issued its first-ever fraud alert via the Internet on November 15, 2001. The alert posted on the OIG's website warned pharmacists that they could be the victims of a scheme to defraud Medicaid. The OIG learned from some pharmacies that they had received faxed documents alleging to be prescriptions. A pharmacy filled several of these prescriptions before becoming suspicious.

The OIG's Internet alert warns pharmacies to possible scams

IPA and IRMA provided valuable assistance by faxing the fraud alert to all their members. The OIG, with the assistance of DPA's Bureau of Comprehensive Health Services, also mailed the alert to every Medicaid-enrolled pharmacy in Illinois. Through this alert, the OIG learned of five additional pharmacies that were targets of similar schemes. The Medicaid Fraud Control Unit has launched an investigation into the matter.

The common elements of the prescriptions were: A legitimate Cook County Hospital physician's name was used; the physician did not sign the prescription; the prescription was written on plain paper; the prescriptions were faxed from one of several currency exchanges; the prescriptions were picked up by a male in his late 20s to early 30s with an Hispanic accent; and the prescriptions were for legitimate Medicaid recipients residing in a Chicago AIDS hospice. The Internet fraud alert advised pharmacies to be wary of the prescriptions meeting these characteristics and to check the physician prescribing the drugs and the Medicaid recipients.

The entire fraud alert can be viewed on the OIG's website at www.state.il.us/agency/oig.

Program Integrity Initiatives

Each year the OIG performs thousands of activities, including fraud prevention research, financial audits, quality of care reviews, Medicaid eligibility reviews, investigations of employees and contractors, welfare fraud investigations, safety monitoring and special projects aimed at identifying and solving specific problems. The activities lead, in some cases, to sanctions against Medicaid providers, recovery of overpayments from Medicaid providers, criminal action against Medicaid providers and public aid clients, restriction of recipients who abuse their Medicaid privileges, development of new fraud initiatives and improved security for employees and visitors to government buildings.

Vigilance is a reality; scrutiny, always a possibility.

Although the OIG will never have the staffing or the resources to target every single Medicaid and public aid transaction, it has been committed to ensuring that each transaction does have the potential of closer scrutiny. More vigilance by the OIG breeds more awareness on the public's part to do the right thing in any transaction involving public monies. That public awareness strengthens the OIG's prevention efforts, which are the first line of defense against fraud and abuse.

Through its multi-faceted activities and initiatives, the OIG has significantly raised the bar so more providers and more recipients may have some direct or indirect contact with the OIG. Reviews of financial records, inspections of providers' and recipients' medical records, on-site provider visits, visits to recipients' homes, telephone calls, letters and face-to-face interviews are among the direct and indirect contacts made by OIG staff.

In a single year using a variety of program integrity approaches from record analyses to direct contacts, the OIG examined the activities of more than 12,000 individual Medicaid providers and more than 18,000 individual recipients. Enhanced monitoring and increased detection mean that vigilance is a reality and scrutiny is always a possibility for every provider and recipient. This report details the specific initiatives that brought these providers and recipients under the OIG's surveillance during calendar year 2001.

Enhanced Recovery Initiative

During calendar year 2001, the number of nursing home audits conducted by outside accounting firms was raised to 200 annually. The projection is that $16.4 million will be recovered annually by this higher number of audits, double the amount when 100 audits were done by outside firms. The OIG began using private auditors in State Fiscal Year (SFY) 1992, starting with 30 audits a year, expanding to 130 audits in SFY 2001 and to 200 in SFY 2002. The OIG encourages nursing homes to have their overpayments recovered by offsets against their regular, monthly Medicaid payments.

Quality Control Projects

The OIG has initiated a number of special projects designed to make direct contact with providers and recipients to determine if they are in compliance with Medicaid policies and practices. While checking for any lapses within the Medicaid billing and health care delivery system, the special projects help to emphasize the OIG's vigilance and the importance that all providers and recipients adhere to program integrity in all their transactions with DPA and DHS.

OIG reviewers question providers and recipients

The special projects are: New Provider Verification, Negative TANF/Medicaid case action reviews, Medicaid Eligibility Quality Control (MEQC), Third-Party Liability (TPL), Random Claims Sampling (RCS), School-Based Health Services, Early Intervention and the KidCare Program Integrity Plan. Each initiative is described below.

New Provider Verification

Starting June 1, 2001, the OIG, in cooperation with DMP, began pre-enrollment site visits to medical transportation and Durable Medical Equipment (DME) providers designated as high risk or lacking licensure or regulation in the State of Illinois. The project's objectives are to confirm a provider's identity and listed business location, a provider's ability to serve Medicaid clients and that a provider understands Medicaid policies for billing and reimbursement.

The OIG's field staff perform these on-site visits during which a questionnaire is administered. The staff asks providers about the information submitted on their Medicaid enrollment application and inquires about ownership and licenses. Individuals and providers are screened to ensure none has been previously barred, suspended or terminated from Medicaid or Medicare.

As of December 31, 2001, 44 DME enrollments had been reviewed. Forty were enrolled, two providers were found to not provide state plan services and needed to enroll through DHS, one enrollment application was returned because the business was not operational and one provider requested withdrawal of the enrollment package.

Reviews of 79 transportation enrollment packages were completed as of December 31, 2001. Sixty-five were recommended for enrollment. Three enrollment packages were returned by DMP after OIG review because the enrollment packages were not complete; two were returned because the billing agent completed the enrollment materials; two were returned because the phone numbers were not correct; two providers requested withdrawal of their enrollment packages; two were returned because the business was not operational; one provider failed to contact the OIG to schedule the site visit resulting in a returned application; and two were found to not provide state plan services and needed to enroll with DHS.

The New Provider Verification project evolved from pilot studies done in 1998 and 2000 to confirm the existence of newly-enrolled providers and their ability to deliver Medicaid-covered services.

Medicaid/TANF Reviews

The U.S. Center for Medicare and Medicaid Services (CMS), formerly the federal Health Care Financing Administration, has concerns that welfare reform may be adversely affecting Medicaid enrollment. The federal agency believes clients are being inappropriately denied or terminated from Medicaid as a side effect of moving them off Temporary Assistance for Needy Families (TANF). CMS conducted a study and suggested Illinois review what is happening in this state to Medicaid clients when TANF has been denied or canceled.

The OIG initiated a review of negative case actions for Medicaid clients who received TANF to determine the accuracy of those actions by DHS local office staff. A case was in error if there were no valid Medicaid reasons for the denial or termination or if the termination notice was not sent or not sent timely. An error was also cited if the TANF case was canceled and a medical assistance only case was opened but a gap occurred in medical coverage.

The sample universe consisted of denials of applications and terminations of cases which were receiving Medicaid and TANF in the same case. A systematic random sample was selected each month from the universe. The OIG completed 467 negative case action reviews from April 2000-March 2001. The error rate for the sample was 2.29% or an estimated 1,811 incorrect cases when projected to the universe of 79,182 cases.

Of the 11 case errors discovered in the sample, six errors or 54.5% were due to TANF cancellations in which Medicaid cases were opened for the persons remaining eligible for Medicaid but a gap occurred in Medicaid coverage. Corrective actions were completed on cases with errors when appropriate. As a corrective action measure, the DPA will issue an educational memorandum to advise DHS's local offices of the proper procedures to avoid gaps in medical coverage.

The OIG continues to monitor Medicaid/TANF negative actions. The office has requested that clients deleted from TANF cases, while the remaining clients remain active, be added to future samples. This will allow the bureau to determine if the action for the single person was correct. The OIG has also requested that clients whose Medicaid coverage expires be added to the study so it can determined if their Medicaid coverage was evaluated correctly. These sample enhancements will enable OIG to review all types of negative case actions.

Medicaid Eligibility Quality Control (MEQC)

The MEQC provides oversight of the Medicaid eligibility determination as administered by DHS. The OIG reviews 600 Medicaid cases a year. Each month, the OIG samples a statistically-reliable number of cases and does reviews to determine if the cases meet state eligibility requirements. After the eligibility review has been completed, the OIG examines paid Medicaid claims related to the cases for possible errors and financial recovery. A payment error rate is determined by comparing the correct and incorrect payments in the sample.

Medicaid Client Satisfaction Survey (MCSS)
The MCSS monitors the integrity of Medicaid in Illinois by measuring client satisfaction with medical services. The survey measures quality, access, utilization and fraud through a survey of clients. The OIG originally conducted surveys from April 1996-March 1999, then resumed the surveys in April 2000 because of DPA's concern with client services. The surveys are administered in conjunction with MEQC reviews. In April 2001, OIG expanded the surveys to include cases receiving Medicaid and TANF.

Third Party Liability (TPL)
Identifying other health insurance coverages for Medicaid clients leads to a savings for Medicaid, which is supposed to be the payer of last resort. Either the insurance pays instead of Medicaid or DPA can collect after a Medicaid payment has been made if a health insurer has been identified. The OIG reviews individual cases and contacts clients with earned incomes of less than $5,000 per quarter and no recorded TPL. The OIG seeks to identify the types of clients likely to have private insurance so they can be profiled to gather TPL information. The OIG reviews about 50 cases per month. DPA's Bureau of Collections does regular mailings to those persons with incomes of more than $5,000 per quarter and no reported TPL to confirm the recipients have no private insurance coverage.

Random Claims Sampling (RCS)
The RCS project is an outgrowth of the Payment Accuracy Review (PAR), completed in 1998. PAR used a statistically-valid, stratified random sample of 599 medical services adjudicated, processed and approved for payment in January 1998 to determine payment accuracy. RCS has been designed to ensure that every paid claim faces the potential of review. A total of 53 reviews have been completed, and so far two cases have been identified with billing irregularities.

Planned for statewide implementation in 2002, RCS will:

- Broaden existing enforcement, increasing the likelihood that perpetrators face scrutiny.
- Deter the submission of erroneous and fraudulent billings.
- Detect Medicaid fraud schemes.
- Identify overall payment and service accuracy rates and rates by key provider groups to help develop future detection methods.

School-Based Health Services
In 1989, the federal Individuals with Disabilities Education Act (IDEA) and its subsequent amendments, mandated that free, appropriate public education in the least restrictive environment for children with disabilities be provided through special education and related services, such as medical services. The services are defined in a child's Individualized Education Program (IEP). The School-Based Health Services program covers children aged 3-21.

If the child is eligible for Medicaid, DPA claims federal matching funds for both direct services through the fee-for service program and for the administrative costs. Before July 2001, the

Illinois State Board of Education handled the claims submission to DPA from the local education agencies (LEA). Effective July 2001, LEAs or their billing agents submit their claims directly to DPA. The OIG was asked to develop a review protocol for the fee-for-service program.

A pilot review was conducted by OIG on two schools in October 2000. Among the errors identified were record-keeping mistakes and payments for services billed on days when the schools were not open. OIG will conduct technical assistance reviews as a second phase of the pilot in 2002. More than 90% of the LEAs are represented by billing agents for the fee-for-service portion of the claims. The OIG will select at least one LEA for each of the 10 billing agents in the state for review.

IDEA makes the same provisions for children from birth to 36 months. At the request of the DHS, the OIG has been researching the administration of the Early Intervention Program for integrity issues and monitoring opportunities.

KidCare Program Integrity Plan

The plan measures DPA's performance administering KidCare and gathers enrollees' opinions as a way of improving the program and increasing enrollment. KidCare extends health care to children whose family incomes are higher than those who qualify for Medicaid. The reviews:

- Determine if children are eligible and appropriately enrolled in KidCare.
- Assess if enrollees are accurately reporting eligibility information to DPA.
- Check if families have been charged correctly for the KidCare Premium Program.
- Determine if DPA pays the correct amounts to persons in the KidCare Rebate Program.
- Measure the accuracy of payments to KidCare application agents.
- Assess if DHS/DPA correctly deny applications or cancel children from KidCare.
- Ascertain enrollees' satisfaction with KidCare and detect any unacceptable practices by KidCare application agents.
- Gather information on why enrollees leave KidCare.

The pilot program ended in September 2001, and the first monthly review of 55 cases began in December 2001.

Investigations

Fraud Prevention Investigations (FPI)

The FPI program has proven its value since its launch in fiscal year 1996. Designed to ensure the integrity of public assistance programs in Illinois and increase taxpayers' savings, FPI has conducted more than 13,000 investigations and identified nearly $31.4 million in projected savings in its first six years. FPI targets error-prone public assistance applications containing suspicious information or meeting special criteria for pre-eligibility investigation. Twenty-three Cook County local offices of DHS administer the program in cooperation with OIG.

FPI saves state $31.4 million in six years

In Fiscal Year 2001 alone, the estimated net savings was more than $8.6 million for all assistance programs – TANF, Medicaid and food stamps. More than 50% of the savings are in the Medicaid program. Of the 4,000 investigations generated during the fiscal year, the program identified 2,273 cases that had benefits either reduced, denied or canceled according to a report done by the OIG.

The OIG and DHS' Division of Community Operations developed the error-prone referral criteria used by local office staff to identify applications for referral to the FPI program. The criteria were revised for Fiscal Year 2001 referrals. For each referral, a private contractor accesses the case by electronic link to the FPI database and enters its investigation report on the same database. The contractor must complete its investigation within five days for food stamp applications and eight days for TANF and Medicaid applications. The times help the state to act quickly to prevent benefits from being paid to persons who are not eligible, which is the FPI program's goal.

False Identities

An OIG investigation revealed a bus driver receiving disability retirement benefits from the Chicago Transit Authority created three false identities and false family members to receive state assistance. From September 1991 to November 2000, the 47-year-old woman received $186,303.19 in cash assistance, food stamps and medical benefits from DHS and DPA. From December 1998 through April 2001, she used her false identities and documents to receive child care overpayments of $21,021.44 from DHS, and from February 1997 through August 1997, she received a $4,557 overpayment from DHS for homemaker services.

The investigation revealed that her spouse also fraudulently received state homemaker services worth $33,937 between October 1997 and June 2001. The couple failed to report their spousal relationship, making them ineligible for the services and payments. The bus driver used variations of her surnames from various marriages and created false birth certificates to obtain identification documents. An OIG investigator discovered the case while investigating multiple assistance cases involving the woman's daughter. The overpayment total for the two clients is $245,818.63. The case was been referred to the Cook County State's Attorney's office for prosecution.

Tip of the Iceberg
When a Rockford, Illinois, woman was arrested by the Illinois State Police for allegedly forging state child care checks, it was just the tip of the iceberg. State Police referred the case to the OIG to determine the extent of the suspect's welfare fraud. The investigator found the suspect had forged 21 child care checks meant for her alleged child care provider and had failed to report the income to her DHS caseworker. The investigator also discovered the suspect had falsified information about a prior child care provider. The suspect had claimed her mother was her child care provider from November 1997-April 1998. The suspect's mother had died in 1993. Delving further into the case, the investigator learned the father of the suspect's children had been living in the home and had been employed full time since January 1995. When interviewed, the suspect and the man confirmed the situation. The suspect had fraudulently received more than $24,000 in child care and food stamp benefits. The case was sent to the Winnebago County State's Attorney's office for prosecution.

Welfare Fraud and Sexual Abuse
An OIG investigator looked into the case of a Randolph County woman who failed to report her husband resided in the home and was employed. The overpayment of TANF and food stamps was $25,450. The state's attorney charged the woman with state benefits fraud. She pled guilty and was sentenced to three years in prison and ordered to repay the state the total amount. While the case was being processed by the court, the husband was arrested on aggravated criminal sexual abuse charges and jailed. While visiting her husband at the County Jail, the woman was also arrested for criminal sexual abuse. The couple allegedly had permitted their 13-year-old daughter to have sex with a 47-year-old male family friend.

Child Care Fraud
The OIG investigated a contractor for alleged fraud involving child care benefits being administered by the Waukegan, Illinois, YMCA. The OIG developed information that supported the allegations. Working with the DHS' Division of Child Care and Development, a computer program was implemented which identified 25 questionable child care cases. The OIG did a quality assurance telephone survey of suspected providers and was able to have clients provide the names of their child care providers. This data was cross indexed to file data from the customer files at the Waukegan YMCA. Eleven suspected cases, involving a total loss of $368,822, were identified.

The State Financial Crimes Task Force (SFCTF) accepted the case. After an exhaustive joint investigation in which an OIG investigator played a crucial role in obtaining a confession of one of the suspects, four ex-YMCA employees were indicted on March 20, 2001. They all pleaded guilty to the charges, were ordered to pay total restitution of $206,476 and were directed to do 80 hours of community service. One defendant served 30 days in jail, and she and the others were given 30 months' probation.

Emergency Child Support Checks
To determine the existence of fraud, the OIG initiated an exhaustive review of the emergency child support payments issued by the Child Support State Disbursement Unit (SDU) between October 1999 and January 2000. The review of the more than 35,000 checks began in January 2000, and the final report was issued in June 2001. The OIG's analysis determined that 99.9% of the checks issued during the emergency either went to the legitimate payees or were never cashed. Four checks, valued at nearly $2,900, were determined to be fraudulent.

In one case, a woman who worked for the SDU handling emergency check requests had three checks written to herself. She pled guilty to state benefits fraud, was sentenced to 10 days in jail and two years' probation and was ordered to pay a fine and restitution totaling $5,555. In a second case, a child support payee admitted that he had requested an emergency check to help cover the expenses when the children visited him. His case has been referred to the Jackson County State's Attorney's office for review.

New Provider Sanction Guidelines In Place
The OIG implemented a new set of Medicaid Provider Sanction Guidelines, effective July 1, 2001, replacing ones that had not changed substantially in more than 20 years. The new guidelines are consistent, comprehensive, balanced and supportive of OIG's overall goals of identifying and recovering overpayments and sanctioning providers for bad care and poor services. The guidelines are used by the OIG's Bureau of Medicaid Integrity for peer reviews and audits and by the Bureau of Administrative Litigation for administrative action taken against providers who have been charged with violating the guidelines.

The new guidelines use a progressive or tiered approach to findings and sanctions. Most initial findings against a provider now carry warnings. Second and third findings can lead to suspensions or corporate integrity agreements. Repeat findings or severe infractions can lead to termination from Medicaid participation. The new guidelines serve as general approaches for applying sanctions but are not OIG or DPA rules or policies as such. Provider cases involving unusual circumstances may be dealt with on an individual basis, and the guidelines may not be followed in each and every case.

Security After 9/11
The terrorist attacks in New York City, Washington, D.C., and western Pennsylvania and the deaths from anthrax-laced mail prompted the OIG and DPA to re-examine security measures to protect state employees and visitors to DPA buildings around the state. Existing security measures have been reinforced, and new steps have been taken to protect people and facilities since September 11. Formal security reviews were done at 401 S. Clinton and the Thompson Center in Chicago and at agency offices in Kankakee, Joliet and Rockford. The electronic access control systems were enhanced at Bloom, Bucari, Bell, 1011 S. 6th St., 1001 N. Walnut, 110 W. Lawrence, 808 S. College and 400-412 N. 5th St., all in Springfield.

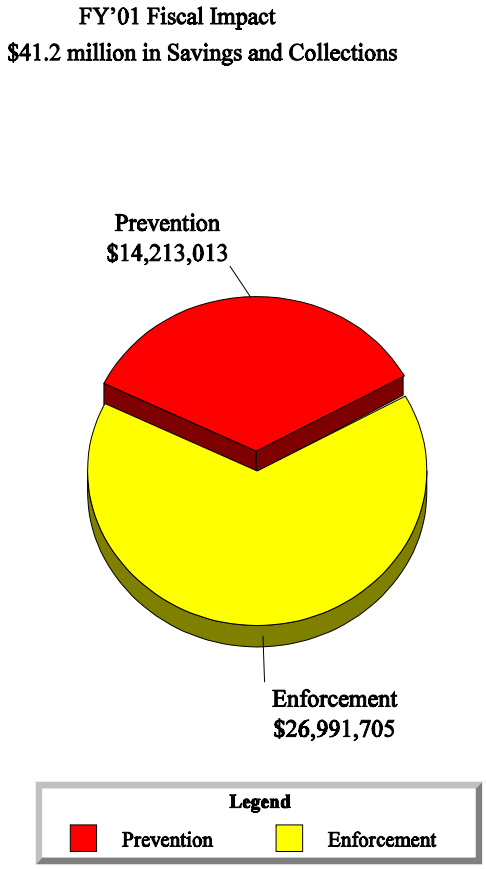
Instructions for handling potentially hazardous mail were shared with all employees, and rubber gloves and breathing masks have been made available to personnel who process mail. DPA has posted the mail-handling instructions on its Intranet.

OIG investigators and security officers underwent formal training or received information packets outlining their duties and priorities during this time of heightened security. OIG representatives also attended Illinois Emergency Management Agency and U.S. Attorney's office briefings on handling potential chemical threats. OIG officials also attended a crisis management for disaster training sponsored by the Illinois Department of Central Management Services.

Defibrillators have been placed at 401 S. Clinton in Chicago and the Bloom Building in Springfield. Similar devices will be purchased and placed in other DPA facilities. A quick reference guide also has been developed for employees to use in case of an emergency.

Fiscal Impact

With a budget of $20.8 million in Fiscal Year 2001, the OIG achieved a savings of $41.2 million through collections and cost avoidances. The OIG employed a variety of prevention and enforcement strategies outlined in this report to achieve those savings.



Prevention Activities:
Recipient Restrictions
Fraud Prevention Investigations
Medicaid Fraud Prevention Executive Workgroup
Fraud Science Team
Payment Accuracy Review Measurement

Enforcement Activities:
Provider Audits
Client Fraud Investigations
HMO Marketing Misconduct
Provider Sanctions
Medicaid Quality Control Reviews
Food Stamp Disqualifications
Physician Peer Reviews
Internal Investigations
Fraud Science Team

Conclusion

The goals of the OIG are to promote program integrity awareness, to implement prevention strategies and to pinpoint and stop abuses of Medicaid and other social services by recipients, providers and agency employees. The OIG's success in achieving these goals has been realized because of the support and coordination occurring within the OIG and with outside partners at the local, state and federal government levels and from the business community.

# # #

OIG Published Reports

Title	Date	Description
Fraud Prevention Investigations: FY01 Cost/Benefit Analysis	**September 2001**	**Identified an estimated $8.6 million in annual net savings for 2001, boosting the total estimated savings to $31.4 million since FPI began in 1996.**
Child Support Emergency Checks	**June 2001**	**An OIG-initiated study determined that 99.9% percent of the nearly $14 million in emergency child support checks were either legitimate or never cashed. Of the 0.1% of the checks that remain unresolved, four have been confirmed as fraudulent.**
Fraud Prevention Investigations: FY00 Cost/Benefit Analysis	**November 2000**	**The program was expanded to all 23 local DHS offices in Cook County. It identified an estimated $8.7 million in net savings, with a benefit of $11.60 for every dollar spent. Since it's inception in 1996, the program's estimated net savings have been nearly $23 million.**
Fraud Prevention Investigations: FY99 Cost/Benefit Analysis	**March 2000**	**Identified $4.5 million in annual net savings with a benefit of $12.12 for every dollar spent.**
Death Notification Project: Identifying the Cause of Delay in Notification	**February 2000**	**Evaluated whether nursing homes or DHS local offices are responsible for case cancellations due to death. The workgroup found that neither party is completely accountable and made recommendations for improvement in the notification process. The workgroup also proposed increased monitoring of the 26 nursing home's identified as having the highest incidences of overpayments due to late notice of death.**
Non-Emergency Medical Transportation Reviews: Focusing on Compliance	**December 1999**	**A selected group of highly paid non-emergency transportation providers claims were examined to determine the type and magnitude of problems in the program. The study confirmed that problems exist in four primary areas: (1) record keeping; (2) prior approvals; (3) billing for excessive mileage and (4) billing for non-existent or non-medical transportation.**
Project Care: Exploring Methods to Proactively Identify Fraud	**December 1999**	**Targeted assistance cases with multiple children for whom one or more had not received medical assistance. Identified ways by which applicants created fictitious children.**

Title	Date	Description
Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments	**December 1999**	**Recommended methods by which non-institutional post mortem payments could be identified more quickly.**
Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 21st Century	**September 1999**	**Verified the cost-effectiveness of searching for assets of LTC applicants.**
Recipient Services Verification Project: RSVP II-Home Health Care	**August 1999**	**Confirmed receipt by clients of home health care services.**
Fraud Prevention Investigations: An Evaluation of Case Selection Criteria and Data Collection Issues	**June 1999**	**Validated the effectiveness of the project's error-prone criteria and processes.**
Fraud Prevention Investigations: FY98 Cost/Benefit Analysis	**December 1998**	**Identified an estimated $4 million in net savings with a benefit of $14.25 for every dollar spent.**
Maintaining A Safe Workplace: Examining Physical Security in DPA and DHS Offices	**October 1998**	**Examined weaknesses in the security of the agencies and proposes several recommendations for improvement.**
Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement	**August 1998**	**First ever such study in the nation. Identified that the department accurately expends 95.28%, plus or minus 2.31%, of total dollars paid.**
Medicaid Client Satisfaction Survey: October 1996-September 1997	**July 1998**	**Measured client satisfaction with quality and access in both fee-for-service and managed care.**
Postmortem Medicaid Payments: Identifying Inappropriate Provider Payments on Behalf of Deceased Clients	**April 1998**	**Confirmed that LTC client cases were not being canceled timely resulting in overpayments to nursing homes and made several recommendations for improvement.**

Title	Date	Description
Fraud Prevention Investigations: FY97 Cost/Benefit Analysis	February 1998	Identified an estimated $3.63 million in net savings with a benefit of $13.02 for every dollar spent.
Medical Transportation: A Study of Payment and Monitoring Practices	December 1997	Identified policy changes and monitoring strategies.
Funeral and Burial: A Review of Claims Processing Issues	October 1997	Examined policies and procedures of the Department of Human Services in paying for client funeral and burial and made recommendations for improvement.
Maintaining A Safe Workplace: Best Practices in Violence Prevention	June 1997	Identified best practices available to prevent violence and recommended a comprehensive workplace violence strategy to protect employees, clients and visitors.
Medicaid Cost Savings: Commercial Code Review Systems May Prevent Inappropriate and Erroneous Billings	May 1997	Recommended a thorough assessment of software systems for prospective review of billings which have the potential to save the State millions.
Fraud Science Team Development Initiative Proposal	April 1997	Proposed a multi-phase project to develop a prepayment fraud surveillance system for Medicaid claims and a complementary set of innovative post-payment review routines to detect inappropriate payments.
Medicaid Client Satisfaction Survey: April 1996-September 1996	April 1997	Measured client satisfaction with quality and access in both fee-for-services and managed care.
Prior Approval Study	May 1996	Surveyed nine state Medicaid agencies and six private payors to gain an understanding of their drug prior approval systems. Also reviewed prior approval statutes, rules, regulations and literature.
Clozaril Report	February 1996	Studied distribution and payment for the anti-psychotic drug Clozaril and made several recommendations for improvement.
Hospital Inpatient Project Summary Report	April 1994	Found hospitals are underpaid about as frequently as they are overpaid. No evidence was found of hospitals systematically upcoding and unbundling.

Most of these reports are available on our web site at www.state.il.us/agency/oig. They can also be obtained by contacting Robb Miller, Inspector General, Illinois Department of Public Aid, at 217-524-7658.

STATISTICAL TABLES

Audits of Medical Providers

The OIG initiates medical audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. Medical audits generally cover an 18-month period and are conducted on institutional and non-institutional providers. When a provider is selected for an audit, the provider is contacted, and records are reviewed onsite by the audit staff. Providers with identified overpayments are asked to either repay the liability, present documentation to dispute the findings or request an administrative hearing. Audits are considered completed upon receipt of the provider's payment, a negotiated settlement or the DPA Director's final decision. The provider may repay the department by check or by a credit against billings, in either monthly installments or a single payment. Because providers are allowed to make payments in installments, collections vary, and the amount reported will often cover audits closed in previous quarters. Collections generally result from audits completed in prior periods. Note: Effective July 1, 1999, collection amounts are taken from a new source – the Public Aid Accounting System (PAAS).

Collection of Overpayments
CY 2001

Audits	353
Collections	$17,121,791.42

Collection of Provider and/or Client Restitutions

Monies collected are from fraud convictions, provider criminal investigations and civil settlements. There is no payback for federal financial participation on restitutions. Restitutions can be paid in one lump sum or by installments and may vary considerably from year to year. The payments depend on when cases are settled and when amounts are ordered to be repaid.

Collection of Provider and/or Client Restitutions
CY 2001

Amount Collected	$2,339,722.95

Refill Too Soon

This table summarizes the Refill Too Soon (RTS) program, as required by Public Act 88-554. RTS is a computerized system of prepayment edits for prescription drug claims. The edits are designed to reject attempts to refill prescriptions within the period covered by a previously paid prescription claim. The estimated savings represents the maximum amount the department could save as a result of RTS edits. Once payment for a prescription is rejected, the prescription is probably resubmitted later, after the first prescription expires. The estimated savings shown in this table represents the value of all rejected prescriptions, but the true savings are probably less.

Refill Too Soon Program
CY 2001

Total Number of Scripts	25,404,897
Amount Payable	$1,142,897,758
Scripts Not Subject to RTS	49,145
Amount Payable	$3,174,851
Scripts Subject to RTS	25,355,752
Amount Payable	$1,139,722,907
Number of Scripts	1,078,262
Estimated Savings	$59,541,763

Provider Sanctions

The OIG acts as the department's prosecutor in administrative hearings against medical providers. OIG initiates sanctions, including termination or suspension of eligibility, recoupment of overpayments, appeals of recoveries and joint hearings with the Department of Public Health to decertify long term care facilities. Cost savings are based on the total dollars paid to terminated providers during the 12 months prior to termination. Cost avoidance is achieved by refusing to pay any claims submitted by a terminated provider between the initiation of the hearing and the actual termination.

Provider Sanctions
CY 2001

Hearings Initiated	
Termination	38
Suspension	12
Denied Application	6
Recoupment	48
Termination/Recoupment	12
Decertification	17
LTC/Hospital Assessment	3
Child Support Sanctions	182
Total	318
Providers Sanctioned	
Termination	21
Voluntary Withdrawal	12
Suspension	3
Denied Application	3
Recoupment	10
Termination/Recoupment	13
Decertification	2
LTC/Hospital Assessment	8
Child Support Sanctions	89
Negotiated Settlements	43
Other P.A. 88-554 Sanctions	0
Total	204
Cost Savings	$4,677,951.32
Cost Avoidance	$519,738.53

Client Eligibility Investigations

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public aid. Investigation results are provided to caseworkers to calculate the overpayments. Cases with large overpayments or aggravated circumstances are prepared for criminal prosecution and presented to a state's attorney or a U.S. attorney. Eligibility factors include earnings, other income, household composition, residence and duplicate benefits. Clients who intentionally violate Food Stamp Program regulations are disqualified for 12 months for the first violation, 24 months for the second violation, permanently for a third violation and 10 years for receiving duplicate assistance.

Client Eligibility Investigations
CY 2001

Investigations Completed	1183
Estimated Overpayments	
Grant and Food Stamps	$2,698,977
Medical	$83,399
Types of Allegations	
Employment	23%
Family Composition	28%
Residence	11%
Interstate Benefits	2%
Other Income	6%
Assets	7%
Multiple Grants	1%
Other	22%
Total	100%
Food Stamp Disqualification	1,410

Child Care Investigations

The OIG conducts investigations when clients or vendors are suspected of misrepresentations concerning child care. Client fraud occurs when earnings from providing child care are not reported, when child care needs are misrepresented or when a client steals the child care payment. Vendor fraud occurs when claims are made for care not provided or for care at inappropriate rates. The results are provided to DHS' Office of Child Care and Family Services. Cases involving large overpayments or aggravated circumstances of fraud are referred for criminal prosecution to a state's attorney or a U.S. attorney.

Child Care Investigations
CY 2001

Investigations Completed	62
Overpayment Identified	$476,082

Client/Vendor Prosecutions

The OIG conducts investigations and refers cases of serious crimes involving large financial losses to a state's attorney or U.S. attorney for criminal prosecution. These cases may involve multiple cases with false identities, failure to report income, long term fraud involving the circumstances of the client and other instances that have resulted in large overpayments to undeserving individuals.

Client/Vendor Prosecutions
CY 2001

Prosecution	
Accepted for Prosecution	71
Overpayment on Cases	$889,440
Convictions	44
Restitutions Ordered	$574,912
Acquittals	0

Medical Abuse Investigations

The OIG investigates allegations of abuse of the Medical Assistance Program by clients. Abusive clients may be placed in the Recipient Restriction Program (RRP). The restriction process begins with a computer selection of clients whose medical services indicate abuse. After reviews by staff and medical consultants, clients are restricted to a primary care physician, pharmacy, or clinic for 12 months on the first offense and 24 months on a second offense. Services by other providers will not be reimbursed unless authorized by the primary care provider, except in emergencies. Abusive clients may choose to enroll in an HMO as an alternative to RRP.

Medical Abuse Investigations
CY 2001

Medical Overutilization	
12 Months	
Recipient Reviews Completed	4,506
Recipients Restricted for 12 months as of 01-01-01	874
Recipient Restrictions Added	574
*Recipient Restrictions Released	609
Recipients Restricted for 12 months as of 01-31-01	764
24 Months	
Recipient Re-evaluations Completed	654
Recipients Restricted for 24 months as of 01-01-01	302
Recipient Restrictions Added	15
*Recipient Restrictions Released	86
Recipients Restricted for 24 months as of 01-31-01	226
Recipients opt for an HMO vs. Restrictions as of 01-01-01	72
Recipients opt for an HMO vs. Restrictions as of 01-31-01	64

*Releases are a result of: cancellation of Medicaid eligibility, death of recipient, opting to select an HMO or program compliance.

HMO Marketer Investigations

The OIG monitors marketing practices to ensure clients have the opportunity to make an informed choice when enrolling with an HMO and to prevent HMOs from avoiding the sickest clients. The DPA's Bureau of Managed Care maintains a toll-free complaint hotline from which the majority of referrals are received. Marketers who have engaged in misconduct or fraudulent marketing practices are removed from the DPA's HMO Marketer Register, which lists HMO marketers from whom the DPA will accept enrollments.

HMO Marketer Investigations
CY 2001

Types of Allegations	
Fraud	41
Misrepresentation	56
Unethical Practices/Other	3
Total	100
Findings	
Substantiated	36
Unsubstantiated	13
Unable to Determine	51
Total	100

Internal Investigations

The OIG investigates allegations of employee and vendor misconduct and conducts threat assessments as part of its security oversight. The investigators are not sworn, do not carry firearms and do not have arrest powers. Investigations include criminal and non-criminal work-rule violations, public aid fraud, criminal code offenses and contract violations. Investigations often reveal violations of several work rules or criminal statutes. A single investigation may cite several employees or vendors. Resolutions may include resignation, dismissal, suspension or a reprimand.

Internal Investigations
CY 2001

Investigations Completed	
Substantiated	157
Unsubstantiated	40
Total	197
Types of Allegations	
Non-Criminal (Work Rules)	
Discourteous Treatment of Others	10%
Failing to Follow Instructions	1%
Negligence in Performing Duties	3%
Engaging in Business with a Client	1%
Incompatible Outside Interests	4%
Sexual Harassment	1%
Release of Confidential Agency Records	1%
Misuse of Computer System	3%
Falsification of Records	5%
Other Work Rule Violations	9%
Work Place Violence	18%
Criminal (Work Rules)	
Misappropriations of State Funds	0%
Attempted Fraud or Theft	2%
Commission of or Conviction of a Crime	5%
Other	0%
Public Assistance Fraud Offenses ILCS Chapter 305	2%
Criminal Code Offenses ILCS Chapter 720	29%
Contract Violations, Security Issues	2%
Special Projects, Background Checks, Assist other Agencies	4%
Total	100%
Misconduct Cited	
Employees	73
Vendors	4
Total	77
Resolutions	
Discharged	16
Resigned	12
Suspensions	24
Other, such as reprimands	26
Administrative Action Pending at Year End	2
No Action Taken	10
Total	90

APPENDIX - AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION

Data showing billing and payment information by provider type and at various earning or payment levels can be accessed at www.state.il.us/agency/oig/docs/2001aggregate.pdf . The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably by type.

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Q = Quarterly Reports
A = Annual Reports

OFFICE OF INSPECTOR GENERAL

404 N. 5th Street
Springfield, Illinois 62762
217-524-7658

www.state.il.us/agency/oig

Welfare/Medical Fraud Hotline 1-800-252-8903 TTY 1-800-447-6404